# *CHANGING THE WORLD: WELCOMING, ACCESSIBLE RECOVERY-ORIENTED CULTURALLY FLUENT* COMPREHENSIVE, CONTINUOUS, INTEGRATED SYSTEMS OF CARE FOR INDIVIDUALS AND FAMILIES WITH PSYCHIATRIC AND SUBSTANCE USE DISORDERS

**Presented by:**

**Christie A. Cline, M.D., M.B.A., P.C.**
**Kenneth Minkoff, MD**

Info@ZiaLogic.org
www.ZiaLogic.org

Kminkov@aol.com
www.kenminkoff.com

# TRANSFORMATION

## *The process of recovery for systems*

- UNIVERSAL WELCOMING PARTICIPATION
- HOPEFUL VISION
- PRINCIPLE DRIVEN
- EMPOWERED PARTNERSHIP
- CONTINUOUS QUALITY IMPROVEMENT
- STRENGTH-BASED
- HONEST SELF-ASSESSMENT
- STEP-BY-STEP MEASURABLE PROGRESS

- *Serenity Prayer of System Change*

*"Co-occurring Psychiatric & Substance Disorders in Managed Care Systems: Standards of Care, Practice Guidelines, Workforce Competencies & Training Curricula"*

CENTER FOR MENTAL HEALTH SERVICES

MANAGED CARE INITIATIVE

CONSENSUS PANEL REPORT

1998

# FIVE SECTIONS OF PANEL REPORT

- I. CONSUMER/FAMILY STANDARDS
- II. SYSTEM STANDARDS/PROGRAM COMPETENCIES
- III. PRACTICE GUIDELINES
- IV. WORKFORCE COMPETENCIES
- V. TRAINING CURRICULA

# CONSUMER/FAMILY SYSTEM STANDARDS

- WELCOMING
- ACCESSIBLE
- INTEGRATED
- CONTINUOUS
- COMPREHENSIVE

## Individuals with Co-occurring Disorders

# PRINCIPLES OF SUCCESSFUL TREATMENT:

Dual diagnosis is an **expectation**, not an **exception.**

This expectation must be incorporated in a **welcoming** manner into all clinical contact, to promote **access** to care and **accurate identification** of the population.

The Four Quadrant Model is a viable mechanism for categorizing individuals with co-occurring disorders for purpose of service planning and system responsibility.

# SUB-GROUPS OF PEOPLE WITH COEXISTING DISORDERS

*Patients with "Dual Diagnosis" - combined psychiatric and substance abuse problems - who are eligible for services fall into four major quadrants*

| | |
|---|---|
| PSYCH. HIGH<br>SUBSTANCE HIGH<br>Serious & Persistent Mental Illness with Substance Dependence<br>**QUADRANT IV** | PSYCH. LOW<br>SUBSTANCE HIGH<br>Psychiatrically Complicated Substance Dependence<br>**QUADRANT III** |
| PSYCH. HIGH<br>SUBSTANCE LOW<br>Serious & Persistent Mental Illness with Substance Abuse<br>**QUADRANT II** | PSYCH. LOW<br>SUBSTANCE LOW<br>Mild Psychopathology with Substance Abuse<br>**QUADRANT I** |

Treatment success derives from the implementation of an **empathic**, **hopeful**, **continuous** treatment relationship, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.

Within the context of the empathic, hopeful, continuous, integrated relationship,

**case management/care**

(based on level of impairment) and

**empathic detachment/confrontation**

(based on strengths and contingencies) are appropriately balanced at each point in time.

When substance disorder and psychiatric disorder co-exist, each disorder should be considered **primary**, and **integrated dual primary treatment** is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.

Both substance dependence and serious mental illness are examples of primary, chronic, biologic mental illnesses, which can be understood using a **disease and recovery** model, with **parallel phases of recovery**.

# PARALLELS
## PROCESS OF RECOVERY

- PHASE 1: **Stabilization**
  - Stabilization of active substance use or acute psychiatric symptoms
- PHASE 2: **Engagement / Motivational Enhancement**
  - Engagement in treatment
  - Contemplation, Preparation, Persuasion
- PHASE 3: **Prolonged Stabilization**
  - Active treatment, Maintenance, Relapse Prevention
- PHASE 4: **Recovery & Rehabilitation**
  - Continued sobriety and stability
  - One year - ongoing

# SUMMARY

- EMPATHIC, HOPEFUL, CONTINUOUS, INTEGRATED MULTIPLE PRIMARY PROBLEM, ADEQUATELY SUPPORTED, ADEQUATELY REWARDED, STRENGTH-BASED, SKILL-BASED, STAGE-MATCHED COMMUNITY BASED LEARNING.

***There is no one type of dual diagnosis program or intervention***. For each person, the correct treatment intervention must be individualized according to subtype of dual disorder and diagnosis, phase of recovery/treatment, level of functioning and/or disability associated with each disorder.

In a **managed care system**, individualized treatment matching also requires multidimensional level of care assessment involving **acuity**, **dangerousness**, **motivation**, **capacity for treatment adherence**, and availability of continuing empathic treatment relationships and other recovery supports.

# Treatment Matching and Treatment Planning

# CCISC CHARACTERISTICS

- 1. SYSTEM LEVEL CHANGE
- 2. USE OF EXISTING RESOURCES
- 3. BEST PRACTICES UTILIZATION
- 4. INTEGRATED TREATMENT PHILOSOPHY

# CHANGING THE WORLD

- A. SYSTEMS
- B. PROGRAM
- C. CLINICAL PRACTICE
- D. CLINICIAN

# 12 STEPS OF IMPLEMENTATION

- 1. INTEGRATED SYSTEM PLANNING
- 2. CONSENSUS ON CCISC MODEL
- 3. CONSENSUS ON FUNDING PLAN
- 4. IDENTIFICATION OF PRIORITY POPULATIONS WITH 4 BOX MODEL
- 5. DDC/DDE PROGRAM STANDARDS
- 6. INTERSYSTEM CARE COORDINATION

# 12 STEPS OF IMPLEMENTATION

- 7. PRACTICE GUIDELINES
- 8. IDENTIFICATION, WELCOMING, ACCESSIBILITY: NO WRONG DOOR
- 9. SCOPE OF PRACTICE FOR INTEGRATED TREATMENT
- 10. DDC CLINICIAN COMPETENCIES
- 11. SYSTEM WIDE TRAINING PLAN

# 12 STEPS OF IMPLEMENTATION

- 12. PLAN FOR COMPREHENSIVE PROGRAM ARRAY
  - A. EVIDENCE-BASED BEST PRACTICE
  - B. PEER DUAL RECOVERY SUPPORT
  - C. RESIDENTIAL ARRAY: WET, DAMP, DRY, MODIFIED TC
  - D. CONTINUUM OF LEVELS OF CARE IN MANAGED CARE SYSTEM: ASAM-2R, LOCUS 2.0

# DUAL DIAGNOSIS CAPABLE

ROUTINELY ACCEPTS DUAL DIAGNOSIS PATIENT

WELCOMING ATTITUDES TO COMORBIDITY

**CD PROGRAM:** MH CONDITION STABLE AND PATIENT CAN PARTICIPATE IN TREATMENT

**MH PROGRAM:** COORDINATES PHASE-SPECIFIC INTERVENTIONS FOR ANY SUBSTANCE DX.

POLICIES AND PROCEDURES ROUTINELY LOOK AT COMORBIDITY IN ASSESSMENT, RX PLAN, DX PLAN, PROGRAMMING

CARE COORDINATION RE MEDS (CD)

# Dual Diagnosis Capable: DDC-CD

- Routinely accepts dual patients, provided:
- Low MH symptom acuity and/or disability, that do not seriously interfere with CD Rx
- Policies and procedures present re: dual assessment, rx and d/c planning, meds
- Groups address comorbidity openly
- Staff cross-trained in basic competencies
- Routine access to MH/MD consultation/coord.
- Standard addiction program staffing level/cost

# Dual Diagnosis Capable: DDC-MH

- Welcomes active substance users
- Policies and procedures address dual assessment, rx & d/c planning
- Assessment includes integrated mh/sa hx, substance diagnosis, phase-specific needs
- Rx plan: 2 primary problems/goals
- D/c plan identifies substance specific skills
- Staff competencies: assessment, motiv.enh., rx planning, continuity of engagement
- Continuous integrated case mgt/ phase-specific groups provided: standard staffing levels

# DUAL DIAGNOSIS ENHANCED (DDE)

MEETS DDC CRITERIA PLUS:

CD: MODIFICATION TO ACCOMMODATE MH ACUITY OR DISABILITY

MH SPECIFIC PROGRAMMING, STAFF, AND COMPTENCIES, INCLUDING MD

FLEXIBLE EXPECTATIONS; CONTINUITY

MH: ADDICTION TREATMENT IN PSYCH MANAGED SETTINGS (DUAL DX INPT UNIT) OR

INTENSIVE CASE MGT/OUTREACH TO MOST SERIOUSLY MI AND ADDICTED PEOPLE

# Dual Diagnosis Enhanced: DDE-CD

- Meets criteria for DDC-CD, plus:
- Accepts moderate MH symptomatology or disability, that would affect usual rx.
- Higher staff/patient ratio; higher cost
- Braided/blended funding needed
- More flexible expectations re:group work
- Programming addresses mh as well as dual
- Staff more cross-trained/ senior mh supervision
- More consistent on site psychiatry/psych RN
- More continuity if patient slips

# Dual Diagnosis Enhanced DDE-MH

- Meets all criteria for DDC-MH, plus:
- Supervisors and staff: advanced competencies
- Standard staffing; specialized programming:

  a. Intensive addiction programming in psychiatrically managed setting (dual inpt unit; dry dual dx housing, supported sober house)

  b. Range of phase-specific rx options in ongoing care setting: dual dx day treatment; damp dual dx housing

  c. Intensive case mgt outreach/motiv. enh.: CTT, wet housing, payeeship management

# CCISC INITIATIVES
# State/Province

- Alaska – CCISC implementation, COSIG
- Arizona – CCISC implementation, COSIG
- Arkansas – COSIG, CCISC consultation
- California – CCISC consultation
- Colorado – CCISC consult, tool license
- District of Columbia – CCISC implementation, COSIG
- Florida – CCISC consultation, state provider association tool license
- Hawaii – CCISC implementation, COSIG
- Idaho – CCISC consultation 2001
- Louisiana – CCISC implementation, COSIG
- Maine – CCISC implementation, COSIG
- Manitoba – CCISC implementation
- Maryland – CCISC consultation, tool license
- Massachusetts – CCISC consensus 1999

Michigan – CCISC implementation multiple local projects, tool license

Minnesota – CCISC consultation, statewide provider network tool license

Montana – CCISC implementation

New Mexico – CCISC implementation (BHSD), COSIG

New York – CCISC consultation

Oklahoma – CCISC implementation, COSIG

Pennsylvania – CCISC implementation, COSIG

South Carolina – CCISC consultation, tool license

South Dakota – CCISC implementation

Texas – CCISC consultation (state hospitals), COSIG

Vermont – CCISC implementation, COSIG

Virginia – CCISC implementation, COSIG

Wisconsin – CCISC consult, tool license

# CCISC INITIATIVES
# Local / Network (non-state)

- Alabama – Birmingham
- British Columbia – Vancouver Island Health Authority, and multiple locations with tool licenses
- California – San Diego, San Francisco, Placer, Kern, San Mateo Counties, Mental Health Systems, Inc (network)
- Colorado – Larimer County
- Florida – Tampa, Miami, Ft. Lauderdale, West Palm Beach, Pensacola Districts
- Illinois – Peoria (Fayette Companies)
- Indiana – Regional provider network
- Maryland – Montgomery, Worcester, Kent Counties
- Manitoba – Winnipeg RHA
- Michigan – Kent, Oakland, Venture Behavioral Health, CareLink network, Washtenaw, and multiple other networks and counties.
- Minnesota – Crookston
- Missouri – Mark Twain Area Counseling Ctr
- New York – Oneida County
- Nova Scotia – Cape Breton RHA
- Ohio – Akron
- Ontario - Hamilton
- Oregon – Mid Valley Behavioral Care Network
- Pennsylvania – Blair County
- Virginia – Lynchburg (CVCSB)
- Washington – Spokane RSN
- Wisconsin – Green Bay, Milwaukee consultation

# SYSTEM FEATURES

- All systems are complex with unique structures and cultures
- All systems work within the context of limited resources and with complex funding issues
- Data is often inconsistent with epidemiologic findings
- Each has significant strengths and weaknesses at all levels (system, program, clinical practice, and clinician)
- Under utilization of leverage (carrots and sticks)
- Everyone falls into the training trap at some point
- Each is becoming more sophisticated about outcomes measurement (system and clinical) and continuous quality improvement approaches

# PUBLIC BEHAVIORAL HEALTH CARE

- Multiple State Agencies and Governing Bodies
- Multiple Funding Streams
- Multiple Systems of Care
- Severely Limited Resources
- Poverty
- Rural and Urban
- Cultural Diversity

# IDENTIFICATION OF NEED

- Morbidity and Mortality
- Gross Under Identification
- Inefficient Use of Resources
- Unmet Needs

# STRATEGIC ALIGNMENT

- CCISC – Principle-driven Systems Improvement Approach
- CCISC – Supports Implementation of Evidence-based Approaches and Improves Routine Practices
- CCISC – Can be Implemented with Existing Resources Using Traditional Funding Streams

# IMPLEMENTATION

- Top-down/Bottom-up Development
- Aligning the Parts of the System
- Inclusion, not Exclusion (programs and populations)
- Strategic Use of Leverage (Incentives, Contracts, Standards, Licensure, etc.…)
- Outcomes and CQI (CO-FIT 100™)
- Model Programs
- Evaluation of Core Competencies (COMPASS™ and CODECAT™)
- "Action Planning"
- Train-the-Trainers
- "Backfilling"

# STARTING PLACES

- Identification of the Population in Need
- Administrative Barriers – Access: Welcoming, No Wrong Door
- Administrative Barriers – Data Capture: MIS system; feedback
- Administrative Barriers – Fiscal: Billing and auditing practice
- Universal Integrated Screening
- Assessment Process (ILSA™)
- Treatment Matching
- Treatment Planning
- Engagement, Stage of Change and Contingency Management
- Evaluation of Trauma
- Interagency Coordination

# PRINCIPLES OF SUCCESSFUL TREATEMENT…

- Co-morbidity is an expectation, not an exception.
- Treatment success derives from the implementation of an empathic, hopeful, continuous treatment relationship, which provides integrated treatment and coordination of care through the course of multiple treatment episodes.
- Within the context of the empathic, hopeful, continuous, integrated relationship, case management/care and empathic detachment/confrontation are appropriately balanced at each point in time.

# …PRINCIPLES OF SUCCESSFUL TREATEMENT…

- When substance disorder and psychiatric disorder co-exist, each disorder should be considered primary, and integrated dual primary treatment is recommended, where each disorder receives appropriately intensive diagnosis-specific treatment.
- Both major mental illness and substance dependence are examples of primary mental illnesses which can be understood using a disease and recovery model, with parallel phases of recovery, each requiring phase-specific treatment.

# …PRINCIPLES OF SUCCESSFUL TREATEMENT

- ***There is no one type of dual diagnosis program or intervention*.** **For each person, the correct treatment intervention must be individualized according to diagnosis, phase of recovery/treatment, level of functioning and/or disability associated with each disorder, and level of acuity, dangerousness, motivation, capacity for treatment adherence, and availability of continuing empathic treatment relationships and other recovery supports.**

# LINKING PRINCIPLES, IMPLEMENTATION AND OUTCOMES

- Examples:
  - Principle: Co-morbidity is an Expectation, not an Exception
  - CQI Initiative: Removal of Administrative Barriers to Data Collection
  - Measure of Success: Improved Population Identification and Data Collection

# LINKING PRINCIPLES, IMPLEMENTATION AND OUTCOMES

- Examples:
  - Principle: Individualized Treatment Matching according to diagnosis, phase of recovery/treatment, level of functioning/disability, level of acuity, dangerousness, motivation, capacity for treatment adherence, availability of continuing empathic treatment relationships and recovery supports
  - CQI Initiative: Integrated Longitudinal Strength-based Assessments (ILSA™)
  - Measure of Success: Improved Identification of Need and Improved Treatment Matching

# TRAIN THE TRAINER PROGRAM

# ROLES OF THE TRAINER

- Develops Systems and Clinicians
- Identifies Barriers to Implementation
- Informs Policy and Procedure
- Bridges Systems and Clinicians
- Extends Training and TA Capacity

# COMPONENTS OF THE PROGRAM

- Master Trainers
- Master Trainer Sessions
- Master Trainer Curriculum
- Trainings and Technical Assistance
- Development and Feedback Loops